# Improving Chronic Care in Medicare

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Let me thank the committee, Senator Craig and Senator Breaux, for inviting me to discuss chronic care and disease management in Medicare at this forum.

Here are the main points I would like to make:

- Improving care for people with long-term or chronic illnesses is the next great challenge in health care delivery. Any new benefits or changes in Medicare should work toward better chronic care, or at least be consistent with chronic care improvements.

- The term "disease management" has a wide range of meanings, from simple educational programs to specialized programs tailored to help people manage a particular chronic disease, such as diabetes, to comprehensive case management services for patients with multiple chronic conditions.

- Comprehensive health insurance plans like HMOs and PPOs (Preferred Provider Organizations, like many Blue Cross plans) generally have the best incentives to provide chronic care services. Because comprehensive health plans cover the full scope of services, investments in chronic care improvements -- such as improved compliance with drug regimens or in-home monitoring -- can "pay off" in savings from a reduced number of hospitalizations or other expensive health services.

- In general, Medicare's traditional fee-for-service program is not well suited for chronic care, because its claims tend to be based on in-person patient visits or services, its payment processes are separated into distinct silos paid by different contractors, and its reimbursement systems usually do not attempt to reward health providers for superior performance. There are few incentives for excellent chronic care, and many chronic care services go unreimbursed.

- Besides encouraging HMOs and PPOs to join or re-join Medicare, the House and Senate prescription drug bills address chronic care in fee-for-service program through two approaches. Under the first approach, Medicare would enter into contracts with disease management firms or groups offering extra services to supplement a patient's current health care, or to essentially become a patient's case manager and the focal point of his or her care. The second approach would establish pay-for-performance procedures for individual physicians or other health providers.

- Because health policy analysts don't know precisely how to create incentives for chronic care services in fee-for-service Medicare, Congress should concentrate on creating processes that allow "experimentation and evaluation," to find out what works.

- To improve oversight and accountability, Medicare should establish a de-centralized management system, with local Medicare medical directors and administrators. Congress and the national Medicare administration should evaluate local programs for effectiveness, and determine which programs actually improve patient outcomes and reduce costs.

**The Chronic Care Challenge**

The next great challenge for Medicare will be shifting the program's emphasis toward chronic care. Medicare has always been a reliable bill payer when beneficiaries suffered an acute health care crisis requiring hospitalization or extensive medical procedures.

Now, Medicare must learn how to better help the increasing number of seniors with chronic illnesses stay out of the hospital and maintain the best possible health and quality of life. This will be is a key to improved health outcomes, higher quality health care, and greater value for every health dollar spent.

Chronic care can involve helping people and their families manage their ailments so that fewer hospital or physician visits are necessary, and sudden health crises are avoided. It can include care coordination, so that a patient's physician or nurse can help patients with multiple chronic illnesses get the medical and community services they need, without undue duplication or lack of communication between health providers.

Because Medicare covers seniors and workers with long-term disabilities -- precisely the people most likely to have chronic or ongoing health problems -- Medicare beneficiaries have the most to gain from continuity of care and comprehensive, coordinated care management systems.

However, Medicare's traditional fee-for service program is not well suited to provide disease management and coordinated chronic care services, for the following reasons:

1. ***The fee-for-service program is not designed to pay for performance.*** Medicare's fee-for-service program does an excellent job paying claims, but by its very nature as a fee-for-service program it generally does not discriminate among health providers. It does not single out only certain favored providers -- known to provide superior care for patients with chronic illnesses -- for the extra payments they might deserve. Medicare generally cannot require that care be provided via established "best practices" (where such a consensus exists). The fee-for-service program does not usually know when uncoordinated care is being provided, or when multiple health providers treating a patient without communicating with each other may be unintentionally working at cross purposes.

   The best chronic care often takes place *between* regular hospital or physician visits and may not involve a face-to-face contact with a health provider. But fee-for-service insurance generally pays for discrete health services provided to patients in person. It is not easy for a fee-for-service program to devise cost-effective ways to pay for between-visit care, or for communications between health providers that occur between in-person patient visits.

2. ***Medicare's benefits are separated in to distinct silos.*** For example, hospital care is paid through "Part A" contractors. Physician and many outpatient services are paid by "Part B" contractors. The Medicare prescription drug bills being reconciled in conference committee would create a new, separate set of Medicare contractors to pay for drug benefits.

   Separated, unlinked, or uncoordinated benefits can thwart chronic care efforts. In general, health benefits should be integrated under one administrative structure, so that the insurer has the ability and the incentive to evaluate tradeoffs -- for example, emphasizing certain drug regimens known to reduce the incidence or cost of hospitalizations. Even if benefits cannot be fully integrated under one insurance carrier, at the very least they should be linked, so that information can be shared between primary and supplemental insurers.

3. ***The Medicare program is heavily centralized and rules based; evaluation and accountability for results is not easy.*** Medicare's fee-for-service program is accustomed to propagating national payment rules and regulations, not experimenting at the local level. Medicare has regional offices, but the program does not have a significant infrastructure on the ground in local areas. There is limited flexibility to experiment locally and few resources are available for local initiatives.

   Medicare needs the flexibility to create disease and care management programs for Medicare beneficiaries. However, Congress is not going to give Medicare's administrative bureaucracy vast new powers without greatly enhanced accountability and oversight systems. Moreover, disease management is inherently a local system, requiring cooperation between local health providers, community institutions, consumer and seniors' groups, and, in some cases, local government agencies. Medicare probably cannot run effective localized disease management and health improvement programs from its headquarters in Baltimore.

**Chronic Care Via Comprehensive Medicare Health Plans**

In theory, private comprehensive health plans in Medicare -- like HMOs and PPOs -- have incentives to provide comprehensive disease management programs. This is because they could suffer financially if patients suffered health crises and expensive hospitalizations, and could gain financially if better chronic care was able to keep patients out of the hospital.

In reality, private health plans are only beginning to tackle disease management and chronic care. Some HMOs have made great progress. But in some areas of the country, where health plans have not formed tight networks of health providers, they may not have the market clout to really force clinicians to do a better job. In other areas, health plans have emphasized short-term cost savings over long-term chronic care programs within their networks.

The incentive to provide chronic care services is strongest if Medicare's HMO and PPO plans believed many of their patients would be enrolled for a long period of time. It could take several years for investments in some chronic care services to "pay off" in better health and few health crises. Therefore, comprehensive health plans would have greater incentives to provide innovative benefits and services for patients with chronic illnesses if they believed those patients will still be enrolled after several years. This argues for a stable, long-term relationship between Medicare and its health plans, which has not been the case in many areas of the country under the current HMO program.

**"Experiment and Evaluate: Chronic Care in Fee-For-Service Medicare**

The overarching problems with improving chronic care in Medicare's fee-for-service program are (1) lack of incentives for fee-for-service health providers, and (2) lack of knowledge about which sorts of supplemental programs or reimbursement schemes would improve care and be cost effective.

This is why the key theme for legislators considering various ways to improve chronic care should be: "Experiment and Evaluate."

***Experimenting with Disease Management Programs and Incentives.*** Health specialists don't have a magic formula for creating the best incentives and programs for chronic care. We don't know which ideas will work best, save money, and most improve beneficiaries' health. Therefore, Medicare should try a number of approaches, and then make the results transparent to doctors, hospitals, nurses, patients, health researchers, Congress and the public. We have to allow ideas that work to bubble up into the Medicare system -- there is probably no way to design the right

chronic care programs from the top down.

*Disease Management Services Provided by Specialty Organizations.* One approach that is common to both the House and Senate Medicare and prescription drug bills is an initiative to allow Medicare to contract with organizations or groups for specialty disease management services. These services could range from patient and family education and self-care assistance, to remote monitoring and communication services, and dedicated case management services, where all or most of the patient's care is funneled through their disease management services provider.

An advantage to this approach is that its results could be tested. Congress could evaluate whether or not "control groups" of seniors enrolled in certain types of disease management services seemed to show improved health or lowered costs over time. (These control groups wouldn't be statistically perfect, but if a particular program succeed in a set of counties in one state, it would be reasonable to assume that similar programs would succeed in other nearby counties with similar demographics and patient needs.)

*Reimbursing Chronic Care Services at the Individual Physician or Health Provider Level.* Another approach would be to attempt to create true "pay-for-performance" reimbursement systems within the fee-for-service program. For example, Medicare could set up a local evaluation committees or organizations to work with individual physicians (or nurses or clinics) who wanted to enroll in a pay-for-performance system.

Enrolling physicians would sign a contract agreeing to provide certain services to patients with chronic illnesses in exchange for enhanced or modified payments from Medicare. They would have to acknowledge that Medicare had the right to study their care and practice patterns in great detail, to evaluate whether or not the extra payments were truly working to improve health and reduce costs. The enrolled physician's patients should probably be asked to cooperate as well, perhaps in terms of allowing electronic medical records, remote communications, or making family commitments to help.

In general, fee-for-service plans have a tough time implementing these sorts of programs. The basic rule of fee-for-service health insurance is that the insurance company doesn't pay different amounts to different health providers.

However, a "enroll and evaluate" system would probably be able to sidestep complaints from non-enrolled physicians, since the program would be explicitly designed as voluntary, limited to a certain number or enrollees, based on a publicly transparent selection process, and would require certain investments of enrolled physicians and their patients.

***Decentralized Accountability Structures, With Federal Evaluation.*** Over time, Medicare's operational administration should be decentralized, with local Medicare managers and medical directors given the budgetary resources to create disease management and chronic care initiatives targeted to local needs and health providers. Then, Medicare could evaluate which programs seemed to work and save money over time, and which were not successful. The national administrators, possibly with the help of the General Accounting Office and the Congressional Budget Office, could help evaluate local programs and help Medicare steer other regions or localities toward the most successful approaches. A new Congressional agency or task force specifically charged with advising Medicare and Congress on how various chronic care initiatives were working in Medicare might be very helpful.

**Chronic Care Initiatives in the Medicare Bills**

The House- and Senate-passed Medicare bills take small but significant steps toward establishing chronic care and disease management programs in Medicare.

There are two main goals: (1) to expand the availability of private comprehensive plans like HMOs and PPOs, which have incentives to provide cost effective care by any means, including improved chronic care, and (2) to institute more widespread chronic care programs within the traditional fee-for-service program.

Both bills would expand the availability of private comprehensive plans, and require that those plans have in place various chronic care initiatives.

The bills would spur improved chronic care services to fee-for-service beneficiaries through both targeted disease management efforts delivered by specialty firms or groups, and pay-for-performance systems for fee-for-service health providers delivering certain chronic care or geriatric care-coordination services. The House bill contains the more complete implementation of the first approach; the Senate bill takes steps toward both.

The House bill creates a permanent, nationwide chronic care program within the fee-for-service system with a new regional accountability structure. The House plan paves the way for disease management organizations to serve beneficiaries in the fee-for-service program.

The Senate chronic care initiatives within the fee-service program are limited to large demonstration programs. The demonstrations would include both disease management organizations and also direct payments to physicians providing enhanced chronic care services. The Senate bill contains a large pool of funding for chronic care services beginning in 2009.

***House Chronic Care Proposal.*** The House-passed Medicare bill would create a permanent, nationwide chronic care improvement program for enrollees with chronic health conditions, such as congestive heart failure, diabetes, chronic obstructive pulmonary disease, stroke, or cancer.

Services could include:

- Self-education services that would encourage the beneficiary to take a proactive approach to managing his or her health.
- Support education for health care providers or family members to help the beneficiary meet the goals of the plan.
- Coordination of health services between home and office visits.
- Coordination among health providers to share relevant clinical information, through technology.
- Enhanced use of technology for self-monitoring of vital signs or other clinical information on a daily basis.
- Education on pain management and end-of-life care.

Rather than administering the program from its national headquarters, Medicare would establish regional offices better equipped to understand local chronic care needs and work with local health care providers. The regional oversight and accountability system would allow administrators the flexibility they need, and it would provide headquarters with cross-regional comparisons to evaluate progress and ensure accountability.

Medicare would offer chronic care services to fee-for-service beneficiaries through new contracts with disease management service providers, health insurers, physician groups, or other entities.

Contractors would be required to monitor and report on health outcomes, reductions in medical and treatment errors or hospital re-admittance rates, beneficiary satisfaction, and cost savings. The House bill also requires randomized clinical trials to compare the health outcomes and costs

of seniors enrolled in chronic care improvement programs with those of Medicare beneficiaries who qualify, but decline to enroll in chronic care programs.

The contracts would be on a risk-sharing basis, and Medicare would monitor and certify that fees paid to these chronic care organizations would be offset over time by reductions in fees that otherwise have been paid on the enrollees' behalf (such as for unnecessary hospital or physician visits). That is, the programs are required to be "budget-neutral" (although the proposal doesn't specify a length of time over which budget neutrality would be determined). The House proposal allocates $100 million for the chronic care programs over the first three years. Since the programs would be budget-neutral by some measure, the $100 million is presumably intended for start-up costs, regional offices, and funding for the cost of clinical trials.

***Senate Chronic Care Proposal.*** The Senate's approach to chronic care is based on large demonstration programs. Medicare would then evaluate the demonstrations and provide funds for their continuation and expansion beginning in 2009.

*Complex Clinical Care Management Fee for Physicians.* The first major demonstration program would test the effects of extra payments to physicians who agreed to take on added responsibilities for patients with at least 4 complex medical conditions. Doctors would be eligible for new monthly fees if they agreed to serve as the patient's primary care physician, coordinate care for the patient with families and outside health providers, and maintain the patient's medical records (including those generated by the patient's contacts with other health providers).

The demonstrations would be located in 6 sites across the country, and would extend for up to 3 years. As with the House bill, Medicare would ensure that the demonstrations would be budget-neutral.

*Care Coordination Organizations.* The Senate bill would also create a 6-site demonstration program for care management organizations. Those firms would be able to contract with Medicare on a risk-sharing basis to provide chronic care services for enrollees in Medicare's fee-for-service program. Like the physician fee demonstration, the care management demonstration program would be budget-neutral. It would extend for as many as 5 years.

*Quality of Care Demonstration.* The Senate would establish another 5-year demonstration program for health plans or medical groups desiring to implement certain quality improvement programs. The budget-neutral arrangements would allow Medicare and groups under the demonstration to use alternative benefit or payment regimes that would spur quality and care improvements.

***$6 Billion for Chronic Care Enhancements Beginning in 2009.*** Based on the results of the demonstration programs, the Senate bill would authorize Medicare to spend as much as $6 billion to follow-up on programs that would improve chronic care. The extra funds could be used to expand demonstration programs nationwide, or relax budget-neutrality requirements.

***Perspective.*** The House bill goes much farther than the Senate toward creating a permanent administrative structure to oversee programs designed to improve chronic care. But the Senate's complex clinical care management fee for physicians represents a bold attempt to raise payments to doctors providing needed chronic care services for which Medicare would otherwise not pay.

The Senate bill's complex care demonstration attempts to drive chronic care improvements down to the level of individual physicians who may otherwise not be associated with a health plan, disease management organization, or other network with systems in place to handle chronic care improvements. That is a worthy idea, but it could prove too costly if sufficient oversight and monitoring is not in place. Some physicians may sign up for the extra payments from Medicare

without any real ability to improve their care of patients' chronic conditions.

At the least, the Senate plan should switch to an enrollment process as outlined above, rather than extending extra payments to physicians without demanding much accountability in return. The selection and evaluation process for physicians participating in the complex care demonstration programs should be very careful. Requirements could include development and maintenance of patients' electronic medical records, agreement to provide e-mail or phone consultations with patients and their families, and agreement to provide remote monitoring systems to keep track of patients' day-to-day conditions. As the Senate bill is currently drafted, the requirements for participating physicians are too vague. With a more specific enrollment and qualification system in place, Medicare could be more confident that its extra payments to physicians would pay off in better health for patients, and fewer expensive office visits or hospitalizations.

Since improved chronic care really should be budget-neutral or close to it, at least over a long period of time, the extra funds in the Senate plan might seem unnecessary.

However, the Senate's commitment to funding is helpful. There may be some chronic care improvement programs that are extremely valuable to seniors, but that do not save money, or cost more than would otherwise be the case. Nevertheless some of those programs might create very high value for taxpayers -- even though they cost more, the improvement in health care would be worth it. The Senate bill allocates funds that could allow some of those types of worthy chronic care programs to continue in Medicare, even if they didn't save money on a strict accounting basis.

**Conference Talks on Chronic Care.** We don't know what will emerge from the conference committee. We anticipate that the House program, designed to encourage disease management programs operated by established firms or institutions, will be included. But it is unclear whether or not its regional accountability structure will survive.

The Senate's demonstration program for complex care management will probably also survive, with an enhanced oversight structure that would establish local chronic care quality improvement organizations to enroll physicians, assess their results, certify that their performance met or exceeded quality and outcomes standards for chronic care management. This certification would be a trigger for performance-based bonus payments.

The extra $6 billion pool of funds for chronic care will probably not be included, simply because agreements the conferees have (apparently) reached on other parts of the bill have raised the cost above the $400 billion total budget allocation. In any event, Congress would face a tough choice in deciding whether or not to allocate extra funds for chronic care in fee-for-service programs, or to allocate the funds to help induce the expansion of private comprehensive PPO plans.

Finally, the Medicare conferees will have to decide whether or not to stress rudimentary disease management approaches, such as diabetes education, or complex case management services. The former might be easier, but the latter might be especially cost effective for patients with multiple chronic conditions.